

APPLICATION FOR APPROVAL OF
DRUG THERAPY MANAGEMENT
PHYSICIAN-PHARMACIST AGREEMENT AND PROTOCOLS

1. Contact person's information:

Every approved physician-pharmacist agreement must have a primary contact person. This is the person with whom the Boards of Physicians and Pharmacy or the Drug Therapy Management Joint Committee will correspond. It is this person's responsibility to relay information to the other individuals who are approved to act under the approved physician-pharmacist agreement in a timely manner. If the contact person's information changes, it is the responsibility of the contact person to notify, and to provide the new contact information to, the Board of Pharmacy within 14 days of the change.

Contact's Name _____
Last First Middle Generation (Sr., Jr., etc.)

Mailing Address _____
Number and Street Suite

City State Zip Code

Telephone Numbers: Day() _____ Other () _____
Pager () _____ Fax () _____

Email address: _____

Contact Person's Profession ☐ Physician ☐ Pharmacist

License Number: _____

I agree to provide information provided by the Boards of Physicians or Pharmacy or the Drug Therapy Management Joint Committee to the other parties to this Physician-Pharmacist Agreement in a timely manner and to notify the Board of Pharmacy of any change in my contact information within 14 days of the change.

Signature Date

2. Physician or physicians to work pursuant to this Physician-Pharmacist Agreement.

If more than five physicians are to work pursuant to this Physician-Pharmacist Agreement, please provide the information below on a separate document and include that document with this application.

A. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

B. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

C. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

D. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

E. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

3. Pharmacist or pharmacists to work pursuant to this Physician-Pharmacist Agreement.

Pharmacists who work pursuant to this Physician-Pharmacist Agreement must be approved by the Board of Pharmacy. Please complete a *Pharmacist Information Form*, which is a separate document, for each pharmacist that you list below and provide that from with this application.

Pharmacists:

A. Name: _____
Last First Middle Generation (Sr., Jr., etc.)

License Number: _____

- B. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)
 License Number: _____
- C. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)
 License Number: _____
- D. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)
 License Number: _____
- E. Name: _____
 Last First Middle Generation (Sr., Jr., etc.)
 License Number: _____

4. Protocols under which the parties will perform drug therapy management.

- A. Name of Protocol: _____
- B. Name of Protocol: _____
- C. Name of Protocol: _____
- D. Name of Protocol: _____
- E. Name of Protocol: _____

Be sure to include each protocol and any documentation you believe to be pertinent to the review and approval of any or all of the listed protocols. If you are requesting approval of more than five protocols, please provide on a separate document, the name of protocols not listed on this form and any supporting documentation.

5. Fee

Please include the requisite fee with the application. The fees are as follows.

A. Physician-Pharmacist Agreement and One Protocol Review.....\$250.

B. If more than one protocol is requested to be reviewed, the fee is \$50 per additional protocol. (For example, the fee for the review of a Physician-Pharmacist Agreement and

2 protocols would be calculated as follows. Review of Physician-Pharmacist Agreement and one protocol- \$250 + one additional protocol- \$50= \$300)

C. If the Boards have previously approved a protocol, there is no charge for the review.
Fee Included with this Application: _____

6. Be sure to include the following in your submission.

- ☐ The Physician-Pharmacist Agreement that has been signed by all physicians and pharmacists who are to perform drug therapy management pursuant to it.
- ☐ A Pharmacist Information Form for each pharmacist who is to perform drug therapy management pursuant to the Physician-Pharmacist Agreement.
- ☐ All protocols for which you are requesting approval.
- ☐ Any documentation you believe will help the Boards review and approve your application.
- ☐ An original and four copies of the application.
- ☐ The requisite fee.

7. Checklists (Optional).

Please review the following checklists when preparing the requisite documents for this application:

- ☐ The Physician-Pharmacist Agreement Checklist; and
- ☐ The Protocol Checklist.
- ☐ An original and four copies of the application.

8. Signature.

By signing this application, I solemnly affirm under penalties of perjury that the contents of this application are true to the best of my knowledge, information, and belief.

Signature of Contact Person

Date